The Dental Hygienists' Association of Australia Ltd.

July 2015

Response to the Senate Select Committee on Health's Inquiry into best practice in chronic disease prevention and management in primary health care: Terms of Reference

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About the DHAA Ltd.

The Dental Hygienists' Association of Australia (DHAA) Ltd., established in 1975, is the peak body representing registered dental hygiene service providers. Membership includes registered dental hygienists, oral health therapists, undergraduate dental students and affiliate members from dental industries. The DHAA represents leaders in oral health who have been actively practising evidence based clinical practice and non-communicable disease management for many years. Despite this long history of professional practice, the role and skills of oral health practitioners (dental hygienists and oral health therapists) are not well understood by policy-makers and are therefore outlined below.

The Professional Expertise of an Oral Health Practitioner

Oral health practitioners are professional highly-trained dental practitioners who specialise in preventive oral health, focusing on techniques that ensure oral tissues and teeth are maintained and remain healthy in order to prevent dental disease, especially common chronic diseases such as dental caries, gingivitis and active periodontitis.

Dental hygienists and oral health therapists specialise in disease prevention, through clinical intervention and education. This is fundamental to the management of oral health. The provision of dental health education, including dietary advice and smoking cessation, and clinic procedures such as root debridement also assists patients to manage existing conditions such as periodontal disease, cardiovascular disease, oral cancers, diabetes and respiratory disease (in aged care facilities). Dental hygienists and oral health therapists are the primary preventive oral health providers and are the acknowledged experts in the field of dental disease prevention by our dental professional and health service provider colleagues.

The skills, knowledge and training of the oral health practitioner are extensive. Training includes health sciences, human biology, anatomy and physiology, microbiology, pathology, oral medicine, dental medicine, pharmacology, dental materials, periodontics, risk factors, aetiology of disease, cariology, orthodontics, geriatric dentistry, special needs dentistry, oral health promotion and education, dental public health, preventive dentistry, community dentistry, minimal intervention, dental radiography, temporary restorations, local anaesthesia and clinical practice, including examinations, diagnosis and treatment planning and delivery within scope of practice.

The National Law requires the same level of professional responsibility from dental hygienists and oral health therapists as it does from dentists, dental specialists and dental prosthetists in that all practitioners must be registered with AHPRA, and have their own professional indemnity insurance and radiation licences. They are also required to complete 60 hours of mandatory continuing education in a three year cycle.

Our objective is the effective delivery of quality oral health services, improving oral health and therefore also general health. Oral health practitioners are employed throughout Australia as academics and

educators by tertiary and vocational education providers to develop, deliver and evaluate programs which educate future providers of public and private oral health services. They have a critical role in maintaining standards which deliver the highest possible care to all population groups and in developing education strategies that align with the optimum provision of oral health care within an array of policy frameworks in States and Territories of Australia.

Response to the Terms of Reference

1. Examples of best practice in chronic disease prevention and management, both in Australia and internationally

People with chronic disease are at an increased risk of dental disease. People with a chronic condition are more likely to experience toothache, be uncomfortable with their oral appearance, to avoid certain foods due to oral problems and to experience orofacial pain; they are also more likely to have inadequate dentition (fewer than 21 teeth, which makes it difficult to chew food) than people with no chronic condition.[1]

The success of prevention and early detection programs is well documented, including breast screening and Quit campaigns. Such programs lead to better health outcomes for patients. The two leading oral afflictions, dental caries and periodontal disease, are completely preventable, and the World Health Organisation has identified that these diseases "can be effectively prevented and controlled through a combination of community, professional and individual action". [2] There is a plethora of research documenting the relationship between oral health and systemic illness, in particular links with diabetes, cardiovascular disease, pregnancy outcomes, and obesity have been established. Funding the implementation of oral health promotion and preventive services will have a positive effect on not only oral health, but general health and wellbeing. Conversely, reduced funding in these vital areas will see a decline in not only oral health, but general health outcomes.

Best practice in chronic disease prevention and management (including dental caries and periodontal disease) include identifying the patient level of risk, and the development and implementation of a therapeutic and preventive plan.[3] Treatment should always be prescribed using a minimal intervention approach. Motivating patients to adhere to recommendations from oral health professionals is also an important aspect in achieving successful outcomes.

2. Opportunities for the Medicare payment system to reward and encourage best practice and quality improvement in chronic disease prevention and management

Dental hygiene and oral health therapy are highly qualified preventive professional disciplines. This position is supported by the Australian Industrial Relations Commission (AIRC) 2009 decision via a

[1] AIHW 2012. Chronic conditions and oral health. DSRU research report no. 56. Cat. no. DEN 221. Canberra: AIHW.
[2] Petersen PE. The World Oral Health Report 2003: Continuous improvement of oral health in the 21st century - the approach of the WHO Global Oral Health Programme.
[3] Hurlbutt M. CAMBRA Best practices in dental caries management. RDH, 2011.

successful Award variation application from the DHAA (re MA000027 – Health Professionals and Support Services Award 2010) to remove dental hygienists from the award and have them declared award free. In supporting the DHAA's application, the Full Bench of the AIRC recognised that dental hygienists are not ancillary health care providers and therefore accepted that the closest comparison profession to dental hygiene is the employed dentist.[4] Despite this finding, dental hygienists and oral health therapists have yet to be allocated individual provider numbers, and this impedes patients from accessing services directly, and impedes the profession from using items codes for services provided.

In 2011 DHAA was invited to the roundtable consultation of the National Advisory Council on Dental Health. Suggestions were presented on incorporating dental hygiene services into the Medicare model, including acknowledging dental hygienists and oral health therapists as registered health providers and to ensure service provision is acknowledged in any dental schemes, and discussion regarding direct access and the future issue of provider numbers.[5]

Provision of provider numbers to dental hygienists and oral health therapists will allow greater opportunities to practise in a variety of settings, including residential aged care facilities (RACF's), group homes, wards and units in hospital settings, and homes for the disabled. Recent changes to the scope of practice of dental hygienists and oral health therapists, removing the term "supervision" and focusing on their ability to "exercise autonomous decision making within their particular areas of education, training and competence",[6] reflects the fact that they are not ancillary providers, and should be supported in providing direct access to high need groups.

Many countries around the world recognize the value of preventive dental care and place a high community value on preventive dental services. Many encourage direct access, meaning citizens may see a dental hygienist without first having to see a dentist. In Ontario, Canada, Bill 171 was introduced in 2007 which allows the public to access the dental services of registered dental hygienists. Other countries with similar legislation include the United Kingdom, the Netherlands, New Zealand, Scandinavian countries including Sweden and Norway, and many states in America. A review undertaken prior to the legislative change in the UK highlighted that direct access to dental hygienists resulted in increased access to care, improved patient satisfaction and no significant risks to patient safety.[7] Recommending direct access to preventive oral health services, and supporting the issue of provider numbers to dental hygienists and oral health therapists is in keeping with international, evidence- based trends.

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[4] Rule 5 of the Australian Industrial Relations Commission Rules Work Place Relations Act 1996 (Section 576H of the Act).
[5] DHAA Inc. Submission to the National Advisory Council on Dental Health Roundtable Consultation November 8th 2011
[6] http://www.dentalboard.gov.au/Registration-Standards/Scope-of-practice-registration-standard.aspx
[7] Turner S, Tripathee S, MacGillivray S. Benefits and risks of direct access to treatment by dental care professionals: A rapid evidence review. Final Report to the General Dental Council 2012

3. Opportunities for the Primary Health Networks to coordinate and support chronic disease prevention and management in primary health care;

The World Health Organisation (WHO) has produced two key documents, the *Global Goals for Oral Health*, and *The Global Oral Health Program,* both of which are based on a common risk-factor approach and the imperative to integrate oral health and systemic health messages and services.[8]

Further, the *World Oral Health Report* (2003)[9] stated clearly that the relationship between oral health and general health is proven by evidence. Oral health and general health are related in four major ways:

1. Poor oral health is significantly associated with major chronic diseases, including cardiovascular disease, diabetes, respiratory disease, stroke, kidney disease, peripheral vascular disease, dementia, pneumonia, stomach ulcers, and obesity;

2. Poor oral health causes disability, with not only functional limitations but social impact;

3. Oral health issues and major diseases share common risk factors, including hygiene, diet, smoking, alcohol use, stress and trauma;

4. General health problems may cause or worsen oral health conditions.[10]

The core activities of Primary Health Networks include health promotion, education and prevention, all of which are the focus of services provided by dental hygienists and oral health therapists. [11] The involvement of these preventive oral health practitioners in Primary Health Networks should be facilitated.

4. The role of private health insurers in chronic disease prevention and management

A lack of remuneration for preventive oral health services, particularly oral hygiene instruction and dietary advice, discourages dental practitioners from providing these necessary services, and de-values the importance of these services. A lack of remuneration has been identified by dental practitioners as a barrier to providing dietary advice in the dental setting[12]; removing such a barrier will increase the provision of preventive messages, and improve patient health outcomes. Further, there is no billable item code for smoking cessation, despite the well-established role of dental practitioners in providing this guidance and advice.

[8] Monajem S. Integration of oral health into primary health care: the role of dental hygienists and the WHO stewardship. Int J Dent Hygiene 4, 2006; 47–5
[9] The World Oral Health Report 2003. Continuous improvement of oral health in the 21st century- the approach of the WHO Global Oral Health Programme.
[10] DHSV report
[11] Monajem S. Integration of oral health into primary health care: the role of dental hygienists and the WHO stewardship. Int J Dent Hygiene 4, 2006; 47–5
[12] Franki J, Hayes MJ, Taylor JA. The provision of dietary advice by dental practitioners: a review of the literature. Community Dental Health 2014; 31: 9-14.

5. The role of State and Territory Governments in chronic disease prevention and management

State and Territory Governments have a responsibility to ensure the optimal health of the community, and this should include population-wide prevention strategies such as access to a fluoridated water supply. Dental caries, despite being preventable, is still the most common chronic disease in children. Community water fluoridation effectively prevents dental caries, and is a cost-effective and simple measure that is equitable.[13] Consumption of sugars and fermentable carbohydrates also places individuals at high risk of developing dental caries; as such further population wide prevention strategies should include reducing regulation of television advertisements promoting children's foods and drinks, legislation on food labelling and nutritional claims, and food standards for school meals and foods and beverages sold in schools. [14]

The government needs to cease siloing dental care from primary health care; dental care was largely excluded from the Medicare Local process, from the eHealth innovation and at the National Health Workforce Reform Workshop. Integrating oral health into primary health care may provide an opportunity to improve access to affordable dental practitioners, including dental hygienists and oral health therapists. This is particularly important in rural and remote areas where attendance patterns are unfavourable. [15]

The government also has a responsibility to ensure the public have access to timely oral health services. Waiting lists continue to be lengthy, restricting public to access dental care; hygienists urgently need to be utilized in the public settings to address the oral health needs of the public. The government can address this issue by granting funding for the public sector to employ hygienists.

6. Innovative models which incentivise access, quality and efficiency in chronic disease prevention and management

It is clear that that now defunct Chronic Disease Dental Scheme was flawed in both design and execution, with retrospective analysis revealing the majority of claims were from major cities and for crown and bridge, removable prostheses and restorative work. [16] To ensure sustainability, future schemes should look closely at the types of services funded. Preventive dental services are relatively inexpensive is comparison to restorative and prosthetic treatment; further, preventive services would reduce the need for more invasive treatments.

The cost effectiveness of preventive oral health care has been demonstrated in the literature. As mentioned above, despite being preventable, dental caries is still the most common chronic disease in children. School based dental sealant programs have demonstrated effectiveness with 60% fewer new decayed surfaces. [17] Further, preventive oral health can reduce costs for chronic disease management (see Table 1).

[13] US Dept of Health and Human Services
[14] Raven M. Oral health, dental care and primary health care. PHCRIS Research Roundup. Issue 28, June 2013.
[15] Oral Health and Dental Health Fact Sheet, National Rural Health Alliance, Oct 2013
[16] Australian Health Review
[17] US Dept of Health and Human Services

Table 1: Cost benefit of periodontal therapy[18]

systemic condition:	type 2 diabetes (T2D)	cerebral vascular disease (CVD)	coronary artery disease (CAD)	rheumatoid arthritis (RA)	first preganancy in period 2005-2009
N (with periodontal disease and systemic condition)	91,242	13,007	8,458	81,439	8,342
	mean reduction with periodontal therapy in:				
total medical costs per subject per year	$2,840 (40.2%); p<0.04	$5,681 (40.9%); p<0.04	$1,090 (10.7%); p<0.04	$581 (6.3%); NS	$2,433 (73.7%); p<0.001
hospital admissions per 1,000 subjects per year	26.3 (39.4%); p<0.05	94.4 (21.2%); p<0.002	18.7 (28.6%); p<0.01	6.4 (4.5%); NS	not applicable

There are a number of projects currently underway which are exploring high quality and efficient chronic disease prevention strategies and management, which are described below.

Senior Smiles is an oral health initiative for residents in RACF's, providing older people with preventive oral hygiene care, referral pathways for more complex dental care both on-site at the facilities and at community dental practices on the NSW, Central Coast. This model of care utilizes a Dental Hygienist at RACF's, who provides dental examinations, develops oral hygiene care plans, refers residents to dentists where necessary, and provide oral health education to residents, carers and staff.[19] This model of care has been implemented by Riviera Aged Care, UnitingCare and BUPA Healthcare in facilities on the NSW Central Coast and in Sydney, and has also infiltrated local health districts in Ballina, Wagga Wagga, Queanbeyan and surrounding areas and is gaining interest from private dental practices.

A new Chronic Disease Oral Health Clinic has been created within the Royal North Shore (NSW) Oral Health Department. Stakeholders including the call center, diabetes educators and the transplant clinic were consulted to create a referral process; a referral form was created to expedite the pathway between oral health and chronic disease services. The project is currently underway, with an anticipated completion date of December 2015; outcomes include Quality of Life and improved oral health. The initial response to the project has indicated that it may be beneficial for all patients, rather than only those with a Health Care Card. [20]

The evident Foundation, a Practice-based Research Network in Victoria, is undertaking a study exploring the role of Health Promoting Practices.[21] The study involved both dentists and physiotherapists and their patients, and explore the dissemination of four key messages, encompassing the common risk factors of

[18] Jeffcoat M et al. Periodontal Therapy Improves Outcomes in Systemic Conditions: Insurance Claims Evidence. IADR Oral Presentation, 2014.
[19] http://www.newcastle.edu.au/newsroom/featured-news/senior-smiles
[20] http://www.aci.health.nsw.gov.au/ie/projects/chronic-disease-oral-health-pilot-project
[21] http://www.evident.net.au/LinkClick.aspx?fileticket=pnMRPqYucel%3d&tabid=58&mid=768&language=en-US

diet, physical activity, smoking and alcohol consumption. The project has an anticipated completion date of September 2015.

7. Best practice of Multidisciplinary teams chronic disease management in primary health care and Hospitals

The DHAA supports the alignment of preventive oral health services with the Comprehensive Primary Health Care Model, which emphasizes working within multi-disciplinary teams and multi-sectoral collaborations. Endorsing preventive oral health services in this way will remove one of the most significant barriers to direct public access to preventive oral health services, which would in turn help to reverse the decline in public oral health. These are key reforms identified by Health Workforce Australia, which recognizes that the public needs access to preventive dental services in community settings.[22]

Further, the inclusion of more robust oral health education in the curriculum of medical and allied health students is essential. There is currently very little dental education as a component of undergraduate medical programs in Australia. Arguably, the dental profession tends to view this as a limitation. Part of the solution is greater levels of education and awareness amongst the health student cohort and the health workforce, as well as the population, of oral health/systemic health relationships, especially with advancing age and increasing chronic disease prevalence.

8. Models of chronic disease prevention and management in primary health care which improve outcomes for high end frequent users of medical and health services

Australia's population is aging, and increasingly burdened by co-morbidities thus placing pressure on already limited health services. There is a need to develop sustainable health programs to better service this population before the situation becomes critical. As mentioned earlier, the DHAA supports a Comprehensive Primary Health Care Model, emphasizing working within multi-disciplinary team and multi-sectoral collaborations.

The DHAA has a long history in providing services to Residential Aged Care Facility (RACF) residents and advocates access to quality health services. The DHAA is of the belief that conditions for which hospitalisation can be avoided should be considered a surrogate for the adequacy of our primary healthcare system; potentially unnecessary or avoidable hospitalisation of patients in residential care should be used as a surrogate indicator for poor care in these settings.

Greater links between health groups would benefit the public and provide more extensive opportunities for primary health care. From a dental viewpoint, it is clear that even though there are some in-roads in small pockets of our profession into providing treatment and education for residents (and staff) within RACF's, there is an ongoing demand for further interaction and services Australia-wide, especially in rural and remote locations.

[22] Health Workforce Australia 2011, Scope of Practice Review – Oral Health Practitioners

The DHAA thanks the Committee for the opportunity to comment on these terms of reference. We would be pleased to meet to discuss the issues presented in this submission at your convenience.

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